111TH CONGRESS
1ST SESSION

S. 295

To amend title XVIII of the Social Security Act to improve the quality and efficiency of the Medicare program through measurement of readmission rates and resource use and to develop a pilot program to provide episodic payments to organized groups of multispecialty and multilevel providers of services and suppliers for hospitalization episodes associated with select, high cost diagnoses.

IN THE SENATE OF THE UNITED STATES

JANUARY 21, 2009

Mr. BINGAMAN introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to improve the quality and efficiency of the Medicare program through measurement of readmission rates and resource use and to develop a pilot program to provide episodic payments to organized groups of multispecialty and multilevel providers of services and suppliers for hospitalization episodes associated with select, high cost diagnoses.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Quality and Payment Reform Act of 2009''.

SEC. 2. FINDINGS.

(a) FINDINGS RELATING TO MEDICARE REPORTING OF READMISSION RATES AND RESOURCE USE AND THE MEDICARE FEE-FOR-SERVICE PAYMENT SYSTEM.—Congress makes the following findings:

(1) The Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) does not publically or privately report to health care providers on resource use and, as a result, many health care providers are unaware of their practices with respect to resource use.

(2) In 2008, the Congressional Budget Office reported that areas with higher Medicare spending scored lower, on average, on a composite indicator of quality of care furnished to Medicare beneficiaries.

(3) Feedback on resource use has been shown to increase awareness among health care providers and encourage positive behavioral changes.

(4) The Medicare program pays for all patient hospitalizations based on the diagnosis, regardless of whether the hospitalization is a readmission or the initial episode of care.

(5) The Medicare Payment Advisory Commission reports that within 30 days of discharge from a hospital, 17.6 percent of admissions are readmitted to the hospital. In 2005, the Medicare program spent $15,000,000,000 on such readmissions.

(6) The Commonwealth Fund Commission on a High Performance Health System found that Medicare 30-day readmission rates varied from 14 percent to 22 percent with respect to the lowest and highest decile of States.

(b) FINDINGS RELATING TO THE BUNDLING OF MEDICARE PAYMENTS TO HEALTH CARE PROVIDERS.—Congress makes the following findings:

(1) Bundled payments incentivize health care providers to determine and provide the most efficient mix of services to Medicare beneficiaries with regard to cost and quality.

(2) The Medicare Payment Advisory Commission reports that bundled payments around a given episode of care under the Medicare program would encourage collaboration among providers of services and suppliers, reduce fragmentation in health care delivery, and improve the accountability for cost and the quality of care.

(3) The Medicare Participating Heart Bypass Center Demonstration which was conducted during the period of 1990 to 1996 found that bundled payments for cardiac bypass cases were successful in reducing spending on laboratory diagnostics, pharmacy services, intensive care, physician consults, and post-discharge care while maintaining a high quality of care. The Medicare program saved approximately 10 percent on bypass patients treated under the demonstration.

(4) The 16th Commonwealth Fund/Modern Healthcare Health Care Opinion Leaders Survey, released November 3, 2008, found that more than ⅔ of respondents reported that the fee-for-service payment system under the Medicare program is not effective at encouraging high quality and efficient care and more than ¾ of respondents reported preferring a move toward bundled per patient payments under the Medicare program. Respondents favored shared accountability for resource use as a means for improving efficiency, and at least ⅔ of respondents supported realigning payment incentives for providers of services and suppliers under the Medicare program in order to improve efficiency and effectiveness.

SEC. 3. PAYMENT ADJUSTMENT FOR READMISSION RATES AND RESOURCE USE.

(a) PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''PAYMENT ADJUSTMENT FOR READMISSION RATES AND RESOURCE USE

''SEC. 1899. (a) REPORTING OF READMISSION RATES AND RESOURCE USE.—

''(1) ANNUAL REVIEW.—Beginning not later than 1 year after the date of enactment of this section, the Secretary shall conduct an annual review of readmission rates and resource use for conditions selected by the Secretary under paragraph (5)—

''(A) with respect to subsection (d) hospitals and affiliated physicians (or similarly licensed providers of services and suppliers); and

''(B) with respect to the program under this title.

''(2) REPORTING.—

''(A) TO HOSPITALS AND AFFILIATED PHYSICIANS.—Beginning not later than 1 year after the date of enactment of this section, taking into consideration the results of the annual review under paragraph (1), the Secretary shall

provide confidential reports to subsection (d) hospitals and to affiliated physicians (or similarly licensed providers of services and suppliers) that measure the readmission rates and resource use for conditions selected by the Secretary under paragraph (5).

''(B) TO THE PUBLIC.—Beginning not later than 3 years after such date of enactment, taking into consideration the results of such annual review, the Secretary shall make available to the public an annual report that measures the readmission rates and resource use under this title for conditions selected by the Secretary under paragraph (5). Such annual reports shall, to the extent practicable, be integrated into public reporting of data submitted under section 1886(b)(3)(B)(viii) with respect to subsection (d) hospitals and data submitted under section 1848(m) with respect to eligible professionals.

''(3) DEFINITION OF READMISSION.—The Secretary shall define readmission for purposes of this section. Such definition shall—

"(A) include a time frame of at least 30 days between the initial admission and the applicable readmission;

"(B) capture readmissions to any hospital (as defined in section 1861(e)) or any critical access hospital (as defined in section 1861(mm)(1)) and not be limited to readmissions to the subsection (d) hospital of the initial admission; and

"(C) ensure that the diagnosis for both the initial admission and the applicable readmission are related.

"(4) PENALTIES FOR NON-REPORTING.—The Secretary shall establish procedures for the collection of data necessary to carry out this subsection. Such procedures shall—

"(A) subject to subparagraph (B), provide for the imposition of penalties for subsection (d) hospitals and affiliated physicians (or similarly licensed providers of services and suppliers) that do not submit such data; and

"(B) include a hardship exceptions process for affiliated physicians (and similarly licensed providers of services and suppliers) who do not have the resources to participate (except that

such process may not apply to more than 20 percent of affiliated physicians (or similarly licensed providers of services and suppliers)).

''(5) SELECTION OF CONDITIONS.—

''(A) INITIAL SELECTION.—The Secretary shall select conditions for the reporting of readmission rates and resource use under this subsection—

''(i) that have a high volume under this title; or

''(ii) that have high readmission rates under this title.

''(B) UPDATING CONDITIONS SELECTED.—Not less frequently than every 3 years, the Secretary shall review and update as appropriate the conditions selected under subparagraph (A).

''(6) TIME PERIOD OF MEASUREMENT.—The Secretary shall, as appropriate and subject to the requirements of this subsection, determine an appropriate time period for the measurement of readmission rates and resource use for purposes of this section.

''(7) RISK ADJUSTMENT OF DATA.—The Secretary shall make appropriate adjustments to any data used in analyzing or reporting readmission

rates and resource use under this section, including any data used to conduct the annual review under paragraph (1), in the preparation of reports under subparagraph (A) or (B) of paragraph (2), or in the determination of whether a subsection (d) hospital or an affiliated physician (or a similarly licensed provider of services or supplier) has met the benchmarks established under subsection (b)(1)(A)(i) to take into account variations in health status and other patient characteristics.

''(8) INCORPORATION INTO QUALITY REPORTING INITIATIVES.—The Secretary shall, to the extent practicable, incorporate readmission rates and resource use measurements into quality reporting initiatives for other Medicare payment systems, including such initiatives with respect to skilled nursing facilities and home health agencies.

''(b) PAYMENT ADJUSTMENT FOR READMISSION RATES AND RESOURCE USE.—

''(1) IN GENERAL.—

''(A) BENCHMARKS.—

''(i) IN GENERAL.—The Secretary shall establish benchmarks for measuring the readmission rates and resource use of subsection (d) hospitals and affiliated phy-

sicians (or similarly licensed providers of services and suppliers) under this section.

''(ii) REPORT TO CONGRESS ON METHODOLOGIES USED TO ESTABLISH BENCHMARKS.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the methodologies used to establish the benchmarks under clause (i).

''(iii) RISK ADJUSTMENT OF DATA.—In determining whether a subsection (d) hospital has met the benchmarks established under clause (i) for purposes of the payment adjustment under this subsection, the Secretary shall provide for risk adjustment of data in accordance with subsection (a)(7).

''(B) PAYMENT ADJUSTMENT.—Not later than 3 years after the date of enactment of this section, in the case of a subsection (d) hospital that the Secretary determines does not meet 1 or more of the benchmarks established under subparagraph (A)(i) during the time period of measurement, the Secretary shall reduce the base operating DRG payment amount (as de-

fined in subparagraph (C)) for the subsection (d) hospital for each discharge occurring in the succeeding fiscal year by—

"(i) 1 percent or an amount that the Secretary determines is proportionate to the number of readmissions of the subsection (d) hospital which exceed the applicable benchmark established under subparagraph (A)(i), whichever is greater; or

"(ii) in the case where the Secretary updates the amount of the payment adjustment under paragraph (3), such updated amount.

"(C) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

"(i) IN GENERAL.—Except as provided in clause (ii), in this subsection, the term 'base operating DRG payment amount' means, with respect to a subsection (d) hospital for a fiscal year—

"(I) the payment amount that would otherwise be made under section 1886(d) for a discharge if this subsection did not apply; reduced by

"(II) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of such section 1886(d).

"(ii) SPECIAL RULES FOR CERTAIN HOSPITALS.—

"(I) SOLE COMMUNITY HOSPITALS.—In the case of a sole community hospital, in applying clause (i)(I), the payment amount that would otherwise be made under subsection (d) for a discharge if this subsection did not apply shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) of section 1886 and subparagraph (D) of subsection (d)(5) of such section.

"(II) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the term 'base operating DRG payment amount' means the payment amount under such section.

''(2) SHARED ACCOUNTABILITY.—The Secretary shall examine ways to create shared accountability with providers of services and suppliers associated with episodes of care, including how any penalty could be distributed among such providers of services and suppliers as appropriate and how to avoid inappropriate gainsharing by such providers of services and suppliers.

''(3) ANNUAL UPDATE.—The Secretary shall annually update the benchmarks established under paragraph (1)(A)(i) and the payment adjustment under paragraph (1)(B) to further incentivize improvements in readmission rates and resource use.

''(4) INCORPORATION OF NEW MEASURES.—In the case where the Secretary updates the conditions selected under subsection (a)(5)(B), any new condition selected shall not be considered in determining whether a subsection (d) hospital has met the benchmarks established under paragraph (1)(A)(i) for purposes of the payment adjustment under paragraph (1)(B) during the period beginning on the date of the selection and ending 1 year after such date.''.

(2) CONFORMING AMENDMENT.—Section 1886(d)(1)(A) of the Social Security Act (42 U.S.C.

1395ww(d)(1)(A)), in the matter preceding clause (i), is amended by striking ''section 1813'' and inserting ''sections 1813 and 1899''.

(b) VOLUNTARY PILOT PROGRAM FOR BUNDLED PAYMENTS FOR EPISODES OF TREATMENT.—

(1) INITIAL IMPLEMENTATION.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a pilot program to provide episodic payments to hospitals and other organizing entities for items and services associated with hospitalization episodes of Medicare beneficiaries with respect to 1 or more conditions selected under subparagraph (B).

(B) SELECTION.—The Secretary shall initially implement the pilot program for hospitalization episodes with respect to conditions that have a high volume, high readmission rate, or high rate of post-acute care under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (as determined by the Secretary).

(C) PAYMENTS.—

(i) IN GENERAL.—Under the pilot program, episodic payments shall—

(I) be risk adjusted; and

(II) cover all costs under parts A and B of the Medicare program associated with a hospitalization episode with respect to the selected condition, which includes the period beginning on the date of hospitalization and ending 30 days after the date of discharge.

(ii) COMPATIBILITY OF PAYMENT MECHANISMS.—The Secretary shall, to the extent feasible, ensure that the payment mechanism under the pilot program functions with payment mechanisms under the original Medicare fee for service program under parts A and B of title XVIII of the Social Security Act and under the Medicare Advantage program under part C of such title.

(iii) PROCESS.—Under the pilot program, episodic payments shall be made to a hospital or other organizing entity participating in the pilot program. The par-

ticipating hospitals and other organizing entities shall make payments to other providers of services and suppliers who furnished items or services associated with the hospitalization episode (in an amount negotiated between the participating hospital and the provider of services or supplier).

(iv) SAVINGS.—The Secretary shall establish procedures to ensure that the Secretary, participating hospitals or other organizing entities, providers of services, and suppliers share any savings associated with higher efficiency care furnished under the pilot program.

(D) INCLUSION OF VARIETY OF PROVIDERS OF SERVICES AND SUPPLIERS.—In selecting providers of services and suppliers to participate in the pilot program, the Secretary shall establish criteria to ensure the inclusion of a variety of providers of services and suppliers, including providers of services and suppliers that serve a wide range of Medicare beneficiaries, including Medicare beneficiaries located in rural and urban areas and low-income Medicare beneficiaries.

(E) DURATION.—The Secretary shall conduct the pilot program under this paragraph for a 5-year period.

(F) IMPLEMENTATION.—The Secretary shall implement the pilot program not later than 2 years after the date of enactment of this Act.

(G) DEFINITION OF ORGANIZING ENTITY.—In this subsection, the term ''organizing entity'' means an entity responsible for the organization and administration of the furnishing of items and services associated with a hospitalization episode of a Medicare beneficiary with respect to 1 or more conditions selected under subparagraph (B).

(2) EXPANDED IMPLEMENTATION.—

(A) ESTABLISHMENT OF THRESHOLDS FOR EXPANSION.—The Secretary shall, prior to the implementation of the pilot program under paragraph (1), establish clear thresholds for use in determining whether implementation of the pilot program should be expanded under subparagraph (B).

(B) EXPANDED IMPLEMENTATION.—If the Secretary determines the thresholds established

under subparagraph (A) are met, the Secretary may expand implementation of the pilot program to additional providers of services, suppliers, and episodes of treatment not covered under the pilot program as conducted under paragraph (1), which may include the implementation of the pilot program on a national basis.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subsection.

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